EXHIBIT "2"

GINARTE O'DWYER & WINOGRAD, LLP

JOSEPH A. GINARTE✳
JOHN D. O'DWYER
RICHARD M. WINOGRAD 1□
MANUEL GONZALEZ
JOHN E. BIGGIANI
JORGE L. HERNANDEZ▲
NICHOLAS M. TORRES □
MICHAEL A. GALLARDO □
BARRY D. WEIN
GARY R. NOVINS +
RICHARD L. KUHRT 2
BERNARD LAMBERT 2○
MOISES APSAN □ 2
JESUS J. PEÑA 2

ATTORNEYS AT LAW
305 BROADWAY, SUITE 800
NEW YORK, NY 10007

(212) 267-4185
FAX: (212) 267-4262

WWW.GINARTE.COM

OTHER OFFICES:
PASSAIC, NJ 07055
NEWARK, NJ 07105
ELIZABETH, NJ 07201
PERTH AMBOY, NJ 08861
NEW BRUNSWICK, NJ 08901
UNION CITY, NJ 07087

ROGER GUARDA, CLAIMS MGR.

1 CERTIFIED BY THE SUPREME COURT OF NEW JERSEY AS A CIVIL TRIAL ATTORNEY
2 OF COUNSEL
+ ADMITTED TO NY
▲ ADMITTED TO NJ & PA
□ ADMITTED TO NJ & NY
✳ ADMITTED TO NJ & DC
◆ ADMITTED TO DC, FL & NJ
○ ADMITTED TO U.S. TAX COURT

January 24, 2007

A& A Cable Contractors
12506 Ann Lane
Houston, Tx 77064

Attn: Personnel Department

Re: Employee: Jorge Joya
D/A: 05/15/2006

Dear Sir/Madam:

This office represents your named employee in an action for injuries sustained in an accident on the above date.

We are interested in obtaining from you a complete copy of your records relating to our client's employment with your company to include the following: position held, wage verification, attendance records, medical folder (if one exists), disability and/or workers compensation records (particularly relating to this accident) and copies of any and all W-2 and/or 1099 forms in your possession. We would also appreciate confirmation as to whether or not our client has returned to work since the date of accident and if so, the date returned. Annexed hereto please find a duly executed authorization signed by your employee permitting the release of this information to our office.

Should there be a fee for the reproduction of these documents, kindly inform our office before copying and forwarding. We thank you for your prompt attention herein.

Very truly yours,
Ginarte, O'Dwyer, Winograd
Maggie Tirado
Maggie Tirado, Legal Secretary

MT
Encls

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Jorge Joya		
Patient Address: 18415 Lost Knife Circle, Apt 104, Gaithersburg, MD 20886		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
A & A Cable Contractors, 12506 Ann Lane, Houston, TX 77064

8. Name and address of person(s) or category of person to whom this information will be sent:
Ginarte, O'Dwyer & Wingerad, 305 Broadway, Ste 800, NY, NY 10007

9(a). Specific information to be released:

- ☑ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: Legal Matter	3 Years of this Date
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

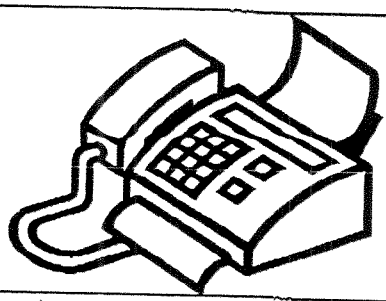
XJJJ
Signature of patient or representative authorized by law.

Date: 01/24/07

GARY R. MOVINS
Notary Public, State of New York
No. 02MO5021832
Qualified in Suffolk County
Commission Expires Dec. 27, 2009

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

EXHIBIT "3"



To: Maggie Tirado
Fax number: 212-267-4262

From: Amy Soliz

Date: 11/14/2007

A facsimile from

A & A Cable Contractors, Inc.
12506 Ann Lane
Houston, TX 77064
Bus: 281-469-2888
Fax: 281-469-2885

Regarding: Jorge Joya case

Comments: The closest location that I can narrow the accident to is the 8600 block of Carpenter Rd., Radisson, NY. Following this coversheet is the First Report of Injury and the Supplemental Report of Injury.

877-404-7999

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, MI): Jova Jorge
2. Sex: F ☐ M ☑
3. Social Security Number:
4. Marital Status:
5. Date of Birth (m-d-y): 11-30-1961
6. Does the Employee Speak English? If No, Specify Language: YES ☐ NO ☑ Spanish
7. Race: White ☐ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☑ Native American ☐ Other ☐
9. Mailing Address (Street or P.O. Box): 8901 Jone Rd # 807 Harris
City: Hou State: TX ZIP Code: 77065
10. Marital Status: Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children: 1
12. Spouse's Name: Juana Hernandez
13. Doctor's Name: N/A
14. Doctor's Mailing Address (Street or P.O. Box): N/A
City: N/A State: ZIP Code:
15. Date of Injury (m-d-y): 5-15-06
16. Time of Injury: am ☐ pm ☑
17. Date Last Time Began (m-d-y): 5-15-06
18. Nature of Injury: CUT
19. Part of Body Injured or Exposed: Face
20. How and Why Injury/Illness Occurred: was pulling a pipe w/a rope, the rope snapped and hit him in the face. injured from cheek to his eye
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (plant, shop, etc.):
23. Address Where Injury or Exposure Occurred (Name of business if residence is a business site; Street or P.O. Box; County): Carpenter Road Radisson, New York
City: Radisson State: New York ZIP Code:
24. Cause of Injury (fell, tool, machine, etc.): Rope
25. List Witnesses: Jorge Zarco
26. Return to work date/or date died (m-d-y): 5-22-06
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Jorge Zarco
29. Date Reported (m-d-y): 5-15-06
30. Date of Hire (m-d-y): 5-8-06
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: Months: 3 weeks Years:
33. Length of Service in Occupation: Months: 2 years Years:
34. Employee Payroll Classification Code:
35. Rate of Pay at time of Injury: $ N/A Hourly $ 600.00 Weekly
36. Full Work Week: HD Hours N/A Days
37. Last Paycheck was: 5-26-06 $ 600 for 1 week Hours or Days
38. Occupation of Injured Worker: helper, Laborer
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑
40. Name and Title of Person Completing Form: Amy Soliz - OFFICE MANAGER
41. Name of Business: A-A Cable Contractors, Inc
42. Business Mailing Address and Telephone Number (Street or P.O. Box; Telephone): 12506 Ann Lane 281.469.2888
City: Hou State: TX ZIP Code: 77064
43. Business Location (if different, enter mailing address) Number and Street: 12506 Ann Lane
City: Hou State: TX ZIP Code: 77064
44. Federal Tax Identification Number: 76-0648286
45. Primary Standard Industrial Classification (SIC) Code (4 digit):
46. Specific SIC Code (4 digit):
47. Texas Comptroller Taxpayer No.: 3-20025-1204-7
48. Workers' Compensation Insurance Company: Texas Mutual Insurance Company
49. Policy Number: TSF-0001130444 20
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐ Not sure
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING): X _____ Title: OFFICE MANAGER Date: 5-30-06

TWCC-1 (2-81) 2/13/91 Rule 120.2

TWCC

ORIGINAL: TO INSURANCE CARRIER COPY: TO EMPLOYEE COPY: TO EMPLOYER

RECEIVED TIME MAY. 31. 2:50PM

TWCC# _____
Carrier# 996000C452359

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name: A-A Cable Contractors, Inc
2. Employer phone #: 281-469-2888
3. Employer mailing address: 12501 Ann Lane Hou, TX 77064
4. Insurance carrier name: Texas Mutual Insurance Company
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☒
   If no, identify contact person and phone # _____
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ DATE _____ no ☐
7. Has the employer requested RTW training from TWCC or the insurance carrier? yes ☐ no ☐
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ DATE _____ no ☒
9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☒

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
    ☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
    ☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
    ☒ d. The injured worker resigned or was terminated from employment. File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name: Jorge Joya
12. SSN: 217-161-9082
13. DOI: 5-15-06
14. Injured worker mailing address and phone #: 18415 Lost Knife #104 Montgomery Village, Maryland 20886
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy): 5-15-06
16. First day of additional lost time or reduced wages (mm/dd/yyyy): N/A
17. Has the injured worker experienced 5 days (cummulative) of lost time or reduced wages as a result of the injury? yes ☒ no ☐
    If yes, the date of the 5th day (mm/dd/yyyy): 5-23-06
18. Date of most recent RTW _____
    ☐ Full duty, full pay
    ☐ Limited duty, full pay
    ☐ Limited duty, reduced pay
19. Has the injured worker resigned, been terminated, or died? yes ☒ no ☐
    date of resignation 5-15-06 date of termination _____ date of death _____
    19a. Reason for resignation/termination: stopped working - injured
    19b. Was the injured worker on limited duty when terminated? N/A yes ☐ no ☐
20. Hours the injured worker was working during the pay period of _____ to _____: 40 hours per week
    Indicated hours are:
    ☐ Increase from pre-injury
    ☒ Same as pre-injury
    ☐ Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of 5-8-06 to 5-15-06: $600 weekly or $_____ hourly
    Indicated wages are:
    ☐ Increase from pre-injury wage
    ☒ Same as pre-injury wage
    ☐ Decrease from pre-injury wage

This form to be filed with: *The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.*

22. To the best of my knowledge, the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
    Submitted by: ☒ Employer ☐ Injured Worker *(if no longer working for the employer where injury occurred.)*

OFFICE MANAGER
Signature and title of person completing this form

6-13-06
Date

TWCC-6 (Rev 2/06) Page 1

TEXAS WORKERS' COMPENSATION COMMISSION

RECEIVED TIME JUN. 14. 3:48PM

05/31/2006 14:41 2814692885 AA CABLE CONTRACTORS PAGE 01/01

877-404-7999

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.): Tova Jorge	2. Sex: F ☐ M ☑
3. Social Security Number:	4. Home Phone: ( )
5. Date of Birth (m-d-y): 11-30-1961	
6. Does the Employee Speak English? If No, Specify Language: YES ☐ NO ☑ Spanish	
7. Race: White ☐ Black ☐ Asian ☐	9. Ethnicity: Hispanic ☑ Native American ☐ Other ☐
8. Mailing Address, Street or P.O. Box: 8901 Jone Rd # 807	County: Harris
City: Hou	State: TX ZIP Code: 77065
10. Marital Status: Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐	
11. Number of Dependent Children: 1	12. Spouse's Name: Juana Hernandez
13. Doctor's Name: N/A	
14. Doctor's Mailing Address (Street or P.O. Box): N/A	
City / State / ZIP Code: N/A	
15. Date of Injury (m-d-y): 5-15-06	16. Time of Injury: : am ☐ pm ☑
17. Date Lost Time Began (m-d-y): 5-15-06	
18. Nature of Injury: Cut	19. Part of Body Injured or Exposed: Face
20. How and Why Injury/Illness Occurred: was pulling a pipe w/ a rope, the rope snapped and hit him in the face. Injured from cheek to his eye	
21. Was employee doing his regular job? YES ☑ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.):
23. Address Where Injury or Exposure Occurred. Name of business if incident on a business site. Street or P.O. Box: Carpenter Road Radisson, New York	County:
City: Radisson	State: New York ZIP Code:
24. Cause of Injury (fall, tool, machine, etc.): Rope	
25. List Witnesses: Jorge Zarco	
26. Return to work date/or expected (m-d-y): 5-22-06	27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Jorge Zarco	29. Date Reported (m-d-y): 5-15-06
30. Date of Hire (m-d-y): 5-8-06	31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: 3 weeks Months / Years	33. Length of Service in Occupation: 2 years Months / Years
34. Employee Payroll Classification Code:	35. Occupation of Injured Worker: helper, Laborer
36. Rate of Pay at this Job: $ N/A Hourly $ 600.00 Weekly	37. Full Work Week is: 40 Hours N/A Days
38. Last Paycheck Was: $ 600 for 1 week Hours or Days 5-26-06	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑
40. Name and Title of Person Completing Form: Amy Soliz - Office Manager	41. Name of Business: A&A Cable Contractors, Inc
42. Business Mailing Address and Telephone Number, Street or P.O. Box: 12506 Ann Lane Telephone: 281.469.2888	43. Business Location (if different from mailing address) Number and Street: 12506 Ann Lane
City: Hou State: TX ZIP Code: 77064	City: Hou State: TX ZIP Code: 77064
44. Federal Tax Identification Number: 76-0648286	45. Primary Standard Industrial Classification (SIC) Code (4 digit):
46. Specific SIC Code (4 digit):	47. Texas Comptroller Taxpayer No.: 3-20025-1204-7
48. Workers' Compensation Insurance Company: Texas Mutual Insurance Company	49. Policy Number: TSF-0001113044 2006
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐	If yes, did you receive them? YES ☐ NO ☐ Not sure
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING): X [signature] - Office Manager	Date: 5-30-06

TWCC-1 (2-91) Rule 120.2

TWCC

ORIGINAL: TO INSURANCE CARRIER COPY: TO EMPLOYEE COPY: TO EMPLOYER

RECEIVED TIME MAY. 31. 2:50PM